PRINTED: 06/24/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	IPLE CONSTRUCTION	UN		SURVEY LETED
		185256	B. WING				C 4.4/204 E
NAME OF PF	ROVIDER OR SUPPLIER	100200	<u> </u>	STREET ADDRES	SS, CITY, STATE, ZIP CODE	1 121	14/2015
PARKVIEV	V NURSING AND REHAE	BILITATION CENTER		200 NURSING H	HOME LANE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	00			
F 157 SS=D	KY24133) was initiated concluded on 12/14/1 unsubstantiated with identified. KY24133 whowever, related deficat 'D' level. 483.10(b)(11) NOTIFY (INJURY/DECLINE/R) A facility must immedican consult with the reside known, notify the residence or an interested family accident involving the injury and has the pot intervention; a significantly of the physical, mental, or produced the potential complications is in either life thresholds the clinical complications is incomplications in the existing form of treatments or a decist the resident from the §483.12(a).  The facility must also	5. KY24123 was no deficient practice was unsubstantiated; cient practice was identified of OF CHANGES OOM, ETC)  Sately inform the resident; ent's physician; and if dent's legal representative of member when there is an resident which results in tential for requiring physician sant change in the resident's sychosocial status (i.e., and it, mental, or psychosocial eatening conditions or one of a need to alter treatment the ded to discontinue and it is not of the promptly notify the resident.	F	57			12/23/15
	and, if known, the res or interested family m change in room or roo specified in §483.15( resident rights under regulations as specific	ident's legal representative ember when there is a ommate assignment as			TITLE		(X6) DATE

02/16/2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 100599

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
						С
		185256	B. WING _			12/14/2015
	ROVIDER OR SUPPLIER  V NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE 200 NURSING HOME LANE PIKEVILLE, KY 41501	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)	
F 157	the address and pho	e 1  ord and periodically update ne number of the resident's or interested family member.	F	157		
	by: Based on interview, of the facility policy it failed to consult with when a change in the occurred for one (1) residents (Resident # with facility staff on 1 #14's skin surroundir surgically produced e attached to collect fe was observed to be r 08/02/15. Further int of the resident's red/c colostomy bag was u attached around the and as a result the re leaked fecal matter of red/excoriated skin. reviews revealed sta #14's physician of the condition until 08/05/ change was identified transferred to the hos	of fourteen (14) sampled #14). Interviews conducted 2/10/15, revealed Resident in his/her colostomy (a exterior opening, with a bag cal waste from the body) and excoriated on the excoriated skin, th				
	-	policy titled "Change in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING _			C <b>2/14/2015</b>	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE PIKEVILLE, KY 41501			2/14/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	clinical nursing staff appropriately interversely physician when a choccurred.  Review of the medic revealed the facility 11/10/14 with diagnor Colon Cancer with a Anemia. Review of Minimum Data Set A 05/17/15 revealed the assistance of two stand toileting. Staff a interviewable with a Status (BIMS) score.  The resident was not unable to be observed.	'dated 11/30/14, revealed was required to recognize, ene, and notify the resident's lange in a resident's condition all record for Resident #14 admitted the resident on language which included History of extention to Colostomy and the resident's quarterly exsessment (MDS) dated the resident required extensive aff members for bed mobility exsessed the resident to be Brief Interview for Mental of 15.	F 1				
	had provided care to and had observed the bag was "leaking" at surrounding the resist and excoriated. The the change in the reas required but was reported.  Interview with Licens on 12/10/15 at 3:05 observed Resident # colostomy site to be appearance on 08/0 had not observed ar	o Resident #14 on 08/02/15 nat the resident's colostomy and the resident's skin dent's colostomy site was red e SRNA stated she reported sident's condition to a nurse unable to recall to whom she  sed Practical Nurse (LPN) #8 PM revealed she had #14's skin surrounding his/her red and "scalding" in 2/15. The LPN stated she and was not aware that the re bag was leaking on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		185256	B. WING			C
NAME OF PE	ROVIDER OR SUPPLIER	100200		STREET ADDRESS, CITY, STATE, ZIP COD		12/14/2015
	10115211 011 001 1 21211			200 NURSING HOME LANE	-	
PARKVIEV	W NURSING AND REHAI	BILITATION CENTER		PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 3	F 1	57		
	resident's physician v resident's skin condit	stated had not contacted the when a change in the ion surrounding his/her fied but stated she should				
	Nurse (APRN) #1 on revealed she was not change in condition where the resident re APRN stated an SRN 08/05/15 that the resirritated" and request resident's skin that su APRN #1 stated she around his/her colost with a "substance lear colostomy site. The skin was so irritated" his/her skin, in refere collection bag to cover and protect the reside she covered Residen with towels and padd resident to a local host treatment. The APRI notified her "quicker for the resident of the	tified of Resident #14's when she was in the facility isided on 08/05/15. The IA had notified her on ident's skin was "red and ed that the APRN assess the arrounded his/her colostomy. observed the resident's skin omy to be red and irritated iking" from the resident's APRN stated the resident's APRN stated the resident's inothing would stick" to ince to applying a waste er the resident's colostomy ent's skin. APRN #1 stated the #14's colostomy opening ing, and transferred the spital for further care and N stated staff should have for sure" related to the oft's skin condition that				
	12/10/15 at 5:20 PM contacted the resider skin surrounding the to be red and irritated colostomy bag was o DON stated she had	ector of Nursing (DON) on revealed staff should have nt's physician when his/her colostomy site was observed I, and the resident's bserved to be leaking. The not been notified that was red and irritated or that				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		C 12/14/2015
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER				1 12/14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 157	Continued From pag	ge 4	F 15	57	
F 309 SS=D		omy bag had been "leaking." ARE/SERVICES FOR IING	F 30	9	12/23/15
	provide the necessa or maintain the high mental, and psychol	receive and the facility must ry care and services to attain est practicable physical, social well-being, in comprehensive assessment			
	by: Based on interview of the facility policy if failed to provide neo maintain the highest and psychosocial w (14) sampled reside Interviews on 12/10/ Resident #14's skin colostomy (a surgica opening, with a bag waste from the body excoriated on 08/02 revealed the resider to be properly attach colostomy site, and colostomy bag leake resident's red/excori transferred to the ho	T is not met as evidenced  record review, and a review t was determined the facility ressary care and services to repracticable physical, mental, fellbeing for one (1) of fourteen ints (Resident #14).  The with facility staff revealed that surrounded his/her fally produced exterior attached to collect fecal was observed to be red and the collect fecal of was observed to be red and the resident's as a result the resident's as a result the resident's and fecal matter onto the atted skin. Resident #14 was respital on 08/05/15 as a result around his/her colostomy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			l	C <b>14/2015</b>
	ROVIDER OR SUPPLIER  N NURSING AND REHA	BILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE  NURSING HOME LANE  (EVILLE, KY 41501	<u>  12/</u>	14/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Care," dated 11/30/1 required to provide n residents that maintal prevent skin problem stoma.  Review of Resident # revealed the facility a 11/10/14 with diagnous and History of Colon Colostomy. Resident assistance of two states bed mobility. The resident assistance of two states bed mobility. The resident mobility. The resident was unable to be obsumed to be obsu	policy titled "Ostomy/Stoma 4, revealed staff was ursing care to facility ined good hygiene and to a around the resident's  #14's medical record admitted the resident on ses which included Anemia Cancer with attention to t #14's quarterly Minimum at (MDS) dated 05/17/15 at required extensive ff members for toileting and sident had been assessed to a Brief Interview for Mental of 15.  Plonger at the facility and served or interviewed.  Registered Nurse Aide (15 at 2:15 PM revealed she ident #14 on 08/02/15 and the resident's colostomy bag SRNA stated the resident's resident's colostomy site ed. SRNA #8 reported the int's condition to a nurse as a unable to recall who she	F	309	DEFICIENCY)		
	Interview with Licens on 12/10/15 at 3:05 F	14's skin surrounding his/her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		C 12/14/2015	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE  ON NURSING HOME LANE  IKEVILLE, KY 41501	12/14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 309	not observed and has Resident #14's coldo 8/02/15. The LPN resident's physiciar and treatment to Richange in the reside surrounding his/her 08/02/15.  Interview with Adva Nurse (APRN) #10 revealed she was richange in condition where the resident #1 stated she obsehis/her colostomy to "substance leaking site. The APRN stairritated "nothing woreference to applying cover the resident's resident's skin. AP Resident #14's cold and padding, and to local hospital for fur APRN stated staff's "quicker for sure" resident's skin conditions of the resident #14 when colostomy site was irritated, and the resident #14 when colostomy site was irritated, and the residented to be leaf	D2/15. LPN #8 stated she had lead not been notified that lead not bear notified that lead not bear not contacted the lead not implemented any new care leadent #14's skin, when a	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION  G	(X3) DAT	E SURVEY IPLETED
	185256 B. WING			C		
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		2/14/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	, ,	that the resident's skin was	F3	09		